MSF Operations & Financial overview

One Year After The Indian Ocean Tsunami Disaster
(December 2005)

- INTRODUCTION -

Days after an enormous tsunami battered parts of South East Asia on December 26, 2004, Médecins Sans Frontières (MSF) teams began working alongside national efforts to provide assistance to individuals in need of medical care, food, water, shelter and other basic necessities.

MSF offices sent over 200 volunteers who concentrated their efforts on hard-hit communities in Sri Lanka and Indonesia, with smaller scale activities in Thailand, Malaysia and India. Assessments completed by MSF teams across the tsunami region showed different needs in different countries, but it became quickly apparent that medical needs were limited.

The mobilisation of national emergency services and civil society saved the most lives in the first crucial days. MSF saw its main role as identifying needs that were being overlooked. In Thailand MSF responded by helping Burmese migrant workers who found themselves in a particularly precarious position. In India, MSF offered psychological support. In Sri Lanka, where the damage was more extensive, MSF initially provided medical assistance and distributed relief goods. But by far the greatest focus of MSF activities has been in Aceh, Indonesia, where many key health personnel were killed in the tsunami, and the health infrastructure destroyed.

Despite predictions and popular belief, huge epidemics did not occur. Now, a year later, MSF has reorientated its work in Indonesia, where 55 international and 350 national staff continue to work, and finished its tsunami-related programmes in other countries. Within Aceh MSF is anticipating scaling down its activities over the next year.

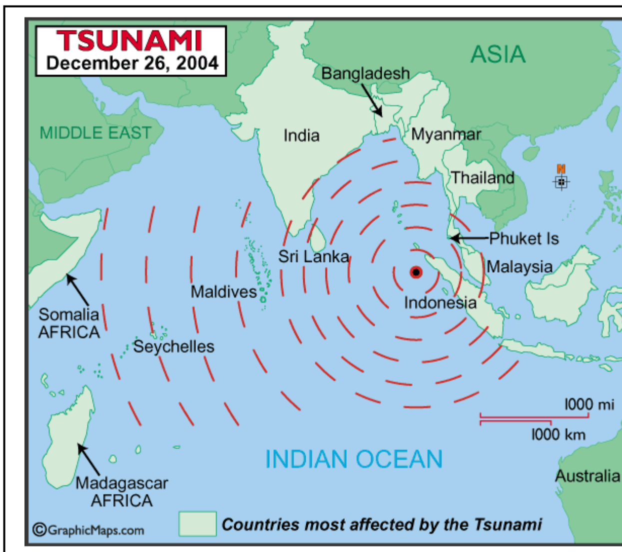
Throughout its intervention, MSF has remained determined that its programmes be driven by need alone, and not by a desire to spend surplus funds. Perhaps the most controversial decision MSF made during the tsunami response was to stop accepting funds which could be used to help victims of the tsunami less than a week after the disaster.

Despite this announcement, in an extraordinary outpouring of solidarity, MSF sections received in total 110 million euros while a forecast indicated that 25 million euros would be sufficient to run programmes for the rest of 2005. MSF decided to contact its donors, asking their permission to derestrict their donations so that they could be used for other emergencies and forgotten crises. The response was overwhelmingly positive. Of all the people contacted, 1% have asked for their money to be refunded rather than redirected.

By the end of 2005, MSF will have used 90.1 million euros or 82% of the Tsunami donations to fund its operations in the Tsunami region (M€ 24.7) and to meet urgent needs in other emergencies and forgotten crises (M€ 65.4) such as the nutritional crisis in Niger, the conflict in Darfur and the earthquake in Pakistan.

Remaining funds allocated for operations in 2006/7 will primarily be used for emergencies and forgotten crises. MSF will nevertheless continue activities in Aceh, where teams still find unmet medical needs with regard to vaccination programmes, mother-child health and with infectious diseases like tuberculosis. Few other organisations are running psychologist-led mental health programmes leaving those traumatised by the tsunami and conflict with few places to turn. MSF is also exploring the inland area of Aceh which few NGOs have accessed but where it is known decades of fighting has taken its toll.

- ONE YEAR OPERATIONS OVERVIEW -



CHRONOLOGY

2004

27/12	Sri Lanka	assessments, relief
	India	assessments, relief
	Malaysia	assessment; no activities
28/12	Indonesia	assessments, relief
29/12	Thailand	assessments
30/12	Thailand	support to hospitals
	Myanmar	assessment, no activities
31/12	India, Andaman	assessment; no activities

2005

14/01 Indonesia, island of Simeulue
assessments, relief, support to hospitals
28/3 Indonesia, Nias assessment, relief
April Sri Lanka programmes handed over
Dec India programmes handed over

In response to the tsunami, MSF's activities focused on Indonesia and Sri Lanka, though staff also provided assistance to people in Thailand and India. Initial exploratory teams assessed needs in Malaysia, Myanmar and Bangladesh as well, but did not find any serious unmet medical needs. Today, MSF continues to carry out tsunami-related operations in Aceh, Indonesia, only.

INDONESIA

MSF was already active in Indonesia before the tsunami struck, assisting patients suffering from infectious diseases and helping victims of violence and natural disasters. On 28 December, the first team arrived in Aceh's regional capital of Banda Aceh. They started seeing patients in a medical clinic and began assessments and relief operations. In the week that followed nearly 200 metric tons of additional medical, water/sanitation and relief materials, as well as dozens of MSF doctors, nurses, psychologists, logisticians, and water and sanitation experts arrived. Additional logistical support was provided by Greenpeace's flagship, the Rainbow Warrior, and while the roads were still impassable, MSF teams travelled by helicopter to areas along the western and northeastern coasts.

By the end of January, the emergency phase had ended. Teams began focusing on rehabilitating health structures and addressing the basic health needs of affected communities. Particular attention was given to people's mental health needs.

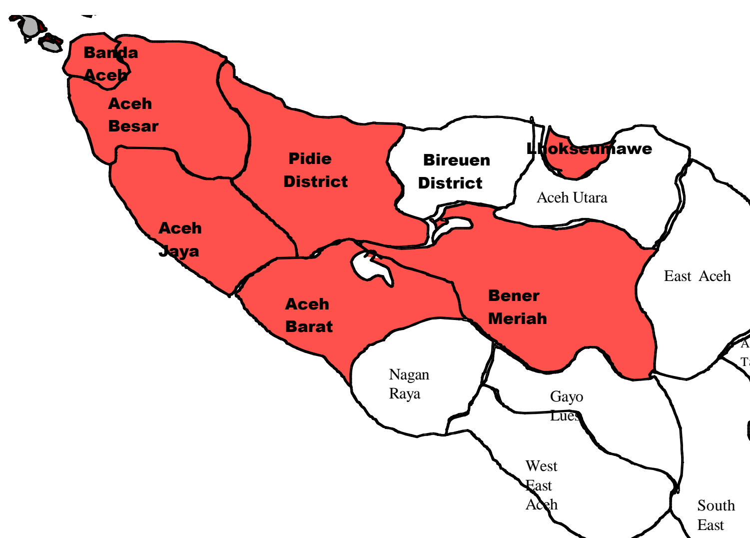
One year on, MSF's distribution of emergency aid items and programmes to provide water and sanitation have for the most part been completed or handed over to partners. However, MSF continues to run mobile clinics to treat people in villages and camps for displaced people. Teams are also setting up basic health services in remote areas including inland areas in the Aceh Barat district and the town of Takengon, in Bener Meriah where access to medical care has been severely limited, due in part to the protracted conflict between rebels and the government in Aceh.

Psychological assistance remains one of the greatest ongoing needs in Aceh, and almost all MSF programs contain a mental health element. Indonesian and international psychologists continue to offer individual treatment to hundreds of patients each month.

OPERATIONAL DATA

Medical Consultations:	**41, 021**
Main Pathologies:	**respiratory infections, skin diseases, acute diarrhoea**
Surgical interventions/admissions:	**517**
Vaccinations:	**111, 789 measles - 10, 130 tetanus**
Psychological Consultations:	**1,770 individual consultations**
Main Complaints:	**sleep disorders, psychosomatic complaints, severe emotional distress, intense sadness, flashbacks**
Rehabilitation of Health Structures:	**27 health centres, 1 hospital, 289 wells cleaned**
Temporary shelter:	**over 10,000 family tents distributed**
Non-food items:	**tens of thousands of items distributed (hygiene, kitchen and tool kits, blankets, mats, jerry cans …)**
Livelihood:	**over 220 boats constructed**
Operational budget:	**M€ 19.44**
Staff in Aceh at the end of Jan. 2005:	**127 international and 150 national**
Staff in Aceh today:	**55 international and 350 national**
	(MSF has been working in Indonesia since 1995)

Currently, MSF is running programmes in 6 districts:



Areas of Aceh where MSF is currently present

BANDA ACEH/ACEH BESAR
Mental health care

ACEH JAYA (Lamno)
Mental health care
1 health clinic (rehabilitated)
Surgery
2 pre-fabricated health units
Mobile clinics
Vaccination (measles and other)
TB
Water & sanitation
Distribution of non-food items
Training Ministry of Health (MoH) staff

BENER MERIAH (Takengon)
Support to basic health care structures
Rehabilitation of health structures (wat/san)
Training MoH staff

ACEH BARAT (Meulaboh)
Health clinics (including in conflict area)
Mental health care
Water & sanitation
Training MoH staff

PIDIE DISTRICT (Sigli and Beureunoun)
Support to 2 hospitals: surgery & post-op care
3 mobile teams
3 health clinics
Support to network of clinics
Mental health care activities
Water & sanitation

ACEH UTARA (Lhokseumawe)
Mental health care

SRI LANKA

MSF's initial **assessments** revealed an uneven destruction of the coastal villages and found health practitioners taking care of the wounded, most of whom were treated within the first three days. Local communities organised accommodation and communal kitchens for the displaced people. MSF teams did respond to specific medical needs and addressed people's needs on an ad-hoc basis. Four weeks after the tsunami, teams were active in Ampara, Batticaloa, Trincomalee, Hambantota, Vanni and Matara districts.

Though a lot of aid poured in, it was not necessarily adapted to people's needs, and coordination of activities was difficult. In the first weeks after the tsunami, some areas received disproportionate amounts of aid and relief items, while others didn't receive anything. In one case, the MSF mobile medical team was the 18th medical team to arrive in a displaced camp in the same day. In some villages people had received so many clothes that they no longer knew what to do with them. Conversely, in one village which had been cut off due to a broken bridge, the team found 975 families who had not yet received any assistance. However, as time went by, some form of relief reached practically all affected communities and by mid-January more than 160 non-governmental organizations (NGOs) were present on the ground.

During the emergency phase, MSF focused on providing **medical consultations** through mobile clinics and existing medical facilities**,** distributing **relief goods** and improving the living conditions for the **displaced people** living in welfare centres and transit camps. Teams provided drinkable **water** and **sanitation** facilities, distributed **tents**, built **temporary shelters** and distributed **non-food items** such as hygiene kits, blankets, sleeping mats, mosquito nets and jerry cans.

In a second phase, teams focused on supporting some of the most vulnerable people in rebuilding their homes and lives. The main communities targeted were fishing villages as well as families living in L.T.T.E (Liberation Tigers of Tamil Eelam) controlled areas who had very little resources. MSF helped with the **clearing of land** plots, the building of **(semi) permanent housing**, and the distribution of tool kits and non-food items such as kitchen utensils. MSF also started providing **psychosocial support** in collaboration with the local NGO Shade and the NGO Payasos Sin Fronteras ('Clowns Without Frontiers').

OPERATIONAL DATA

Main pathologies:	**respiratory tract infections and diarrhoea**
Mental health:	**performances to 7,700 people (Payasos Sin Fronteras); counselling services to 9,200 people (Shade)**
Main complaints:	**deep sense of hopelessness and fear, psychosomatic complaints nightmares, suicidal thoughts.**
Water & Sanitation:	**water for 20,000 people (during 4 months) - over 700 latrines constructed**
Temporary shelter:	**over 2,300 tents distributed - over 1,000 shelters built**
Clearing of debris:	**over 880 land plots cleared (5,000 inhabitants)**
Housing:	**60 semi-permanent shelters built - 105,000 bricks produced and two brick production sites reactivated in LTTE controlled areas**
Non-food items:	**kits to over 6,000 families (hygiene items, blankets, mats, jerry cans …)**
Livelihood:	**1,600 fishing nets distributed, 20 pirogues and 4 motor boats donated to fishing families**
Operational budget:	**M€ 4.10**

Staff at the end of Jan. 2005: 36 international
MSF activities ended in April 2005 (MSF worked in Sri Lanka from 1986 to March 2004, but returned later that year following the tsunami disaster).

INDIA

Because of quick government and community mobilization, emergency medical needs caused by the tsunami were mostly covered in this country. The principal problem for many communities

was psychological trauma, with some people suffering from post-traumatic stress disorder. In response, MSF began offering **psychological support** in **Cuddalore** and **Nagappatinam districts** by training NGO community volunteers as counsellors and psychosocial assistants. In **Tamil Nadu**, in southern India, MSF trained medical students to spot people with health care problems or psychological trauma who were living in displaced camps so that they could be helped more quickly and referred to needed services. The programme is in the process of being handed over.

Operational budget: M€ 0.61
Staff at the end of Jan. 2005: 6 international and 30 national staff and counsellors
The Tsunami-programme is being handed over (MSF has been active in India since 1999 and continues to provide medical and psychosocial assistance in different parts of the country).

THAILAND

In general, the Thai emergency response was found to be fast and well-organized. MSF decided to help improve the situation for **Burmese migrant workers** affected by the tsunami. More than 50,000 Burmese migrants are registered as workers in six provinces along the western coast of southern Thailand, but as many as 500,000 are actually thought to live in the area. An estimated 5,000 Burmese were missing after the tsunami struck the coast and many more found themselves in a precarious situation having lost their papers or job after the tourist industry collapsed. MSF is now working with a local NGO to set up public health workshops to inform migrants from different parts of **Phang Nga province** about basic health care and sanitation and to help them gain access to needed health care.

Operational budget: M€ 0.11
Staff at the end of Jan. 2005: 5 international and 3 national
MSF has been working in Thailand since 1983, providing AIDS care as well as assisting refugees and migrants.

MYANMAR (BURMA)

Two MSF teams were deployed along the south coast of the country. One team arrived on 31st December in Kawthuang to begin an assessment. It found no serious unmet needs. The other team surveyed the Myeik archipelago from north to south using an MSF boat. It found some material damage but did not identify areas in need of emergency assistance.

MSF has worked in Myanmar since 1992 and continues to provide care for people living with malaria, tuberculosis and sexually transmitted infections including HIV/AIDS.

MALAYSIA

In the days following the tsunami, two MSF medical doctors completed an assessment from Penang up to the Thai border. Although they found people grouped in schools and mosques, the authorities were providing clean water, various local organisations had mobilised aid to the displaced and affected populations and health facilities were not overwhelmed. It was decided that no MSF operation was required.

MSF has no programmes in Malaysia.

- ONE YEAR FINANCIAL OVERVIEW -

MSF Operational Budget		**MSF Expenses (end of October)**	
- India	M€ 0.61	- India	M€ 0.52
- Indonesia	M€ 19.44	- Indonesia	M€ 18.05
- Malaysia	M€ 0.03	- Malaysia	M€ 0.03
- Sri Lanka	M€ 4.10	- Sri Lanka	M€ 4.01
- Thailand	M€ 0.11	- Thailand	M€ 0.11
Total	M€ 24.29	Total	M€ 22.72

Fundraising situation

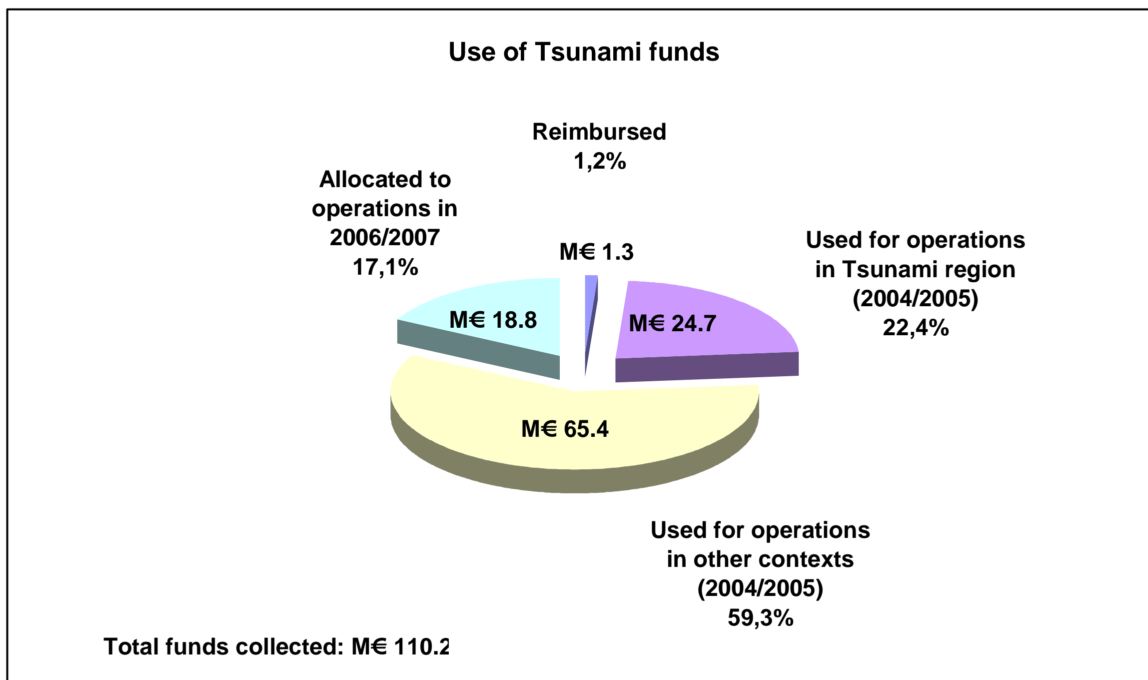
Funds collected	M€	110.19	100%
of which:			
• Funds derestricted or re-directed to other crises	M€	76.77	69.7%
• Funds reimbursed	M€	1.27	1.1%
• Remaining restricted funds	M€	32.15	29.2%
of which:			
o Funds budgeted for Tsunami operations in 2004/2005	M€	24.29	22.0%
o Remaining derestriction target	M€	7.86	7.1 %

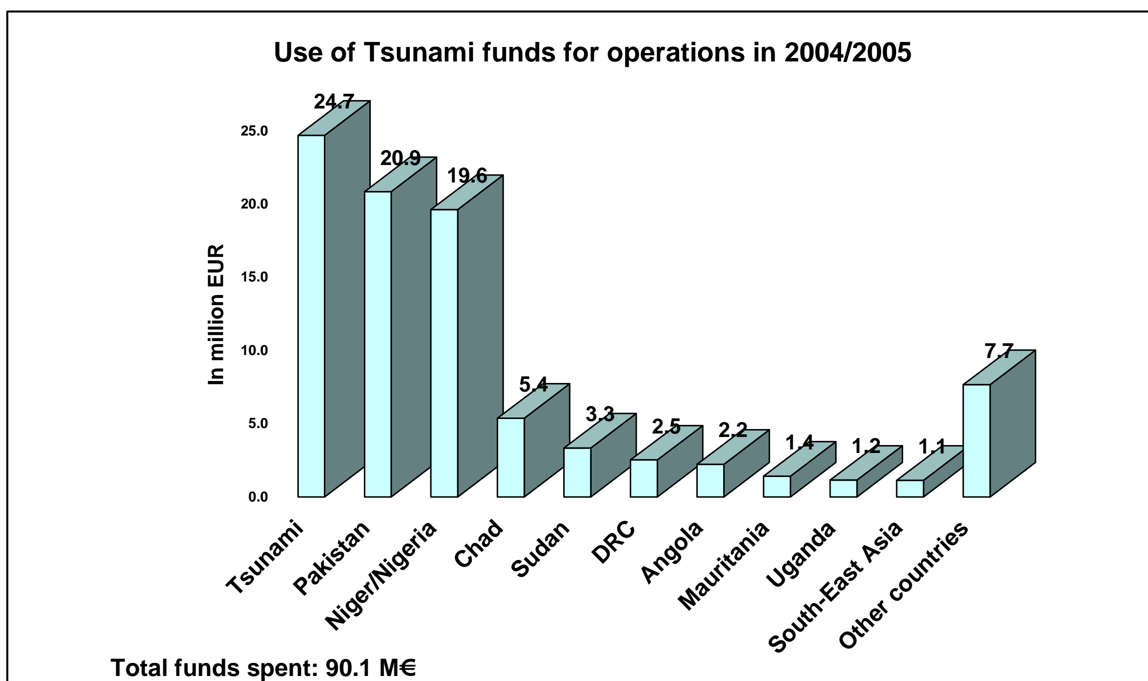
MSF is extremely grateful to its donors for their spontaneous donations following the tsunami and will continue to use their money to provide medical care in the regions affected by the disaster as well as in other emergencies and forgotten crises. The unprecedented generosity after the disaster led to a controversial decision by MSF. In the first week of January, less than a week after the wave hit, MSF announced it would stop accepting funds specifically intended for tsunami victims. In just a few days MSF had received more money than for any other disaster in its history. Despite this announcement, it became evident that MSF would collect more money than it required or had the operational capacity to spend in response to this single emergency.

MSF decided to contact donors, asking their permission to derestrict funds so that they could be used for other emergencies and forgotten crises. The response was overwhelmingly positive. Of those contacted, 1.1% asked for their money to be refunded. Latest figures show that around 69.7% of the total tsunami funds have been derestricted and as of the end of October another 7.1% still needs to be released.

By the end of 2005, MSF will have used 90.1 M€ or 82% of the Tsunami donations to fund its operations in the Tsunami region (M€ 24.7) and to meet urgent needs in other emergencies and forgotten crises (M€ 65.4, see details below). We are heartened by the trust our donors have placed in MSF in allowing us to use their funds where they are needed most urgently.

Use of Tsunami funds - State of affairs (end of 2005)





Of the M€ 24.7 used for operations in the Tsunami region, 400,000 euros or 1,6% involve indirect operational costs. These are part of the costs incurred by the Operations departments for the direct support of this emergency.

The funds redirected to other emergencies and forgotten crises were used in 21 contexts, mainly in Pakistan, Niger/Nigeria, Chad, Sudan, DRCongo and Angola[1] for the following operations :

[1] All 21 contexts are: Angola, Burkina Faso, Chad, China, Colombia, DRCongo, Guinea Bissau, Haiti, India, Ivory Coast, Mali, Mauritania, Mozambique, Myanmar, Niger/Nigeria, Pakistan, Peru, South-East Asia (AIDS care in Thailand; TB care and measles in Indonesia), Sudan, Uganda, Zimbabwe.

Pakistan (earthquake) – Since the devastating earthquake that struck Pakistan on October 8, MSF teams have been supporting national relief efforts and continue to work in 12 permanent sites in Kashmir and the North West Frontier Province. They run two field hospitals, perform surgical interventions, carry out over 1,000 medical consultations each day, vaccinate children against measles and injured people against tetanus and continue to distribute emergency shelter, blankets as well as cooking and hygiene kits.
Staff in this emergency (end of 2005): 120 international and 350 national.

Niger/Nigeria (malnutrition) – While malnutrition is a chronic problem in Niger, 2005 saw the emergence of a malnutrition epidemic of exceptional proportions. Despite emergency alerts launched by MSF as soon as April, the international response to the nutritional crisis in Niger was late and inadequate. Over 60,000 severely malnourished children were admitted to MSF feeding centres, 85% of whom recovered. In neighbouring Nigeria malnutrition among children was mainly the result of a measles epidemic in a country with low vaccination coverage.
Staff in this emergency (end of 2005): 86 international and 1,035 national.

Chad (Darfur refugees, malnutrition & measles) – In the last two years, an estimated 200,000 refugees from the Sudanese region of Darfur have sought refuge in neighbouring Chad where they face harsh living conditions in camps. MSF has been providing medical care, surgery, pediatric and maternal care in Adré hospital, which is accessible to the refugees, as well as food and shelter in four camps. Following an outbreak of meningitis, MSF vaccinated about 70,000 refugees and residents at the beginning of 2005. Measles outbreaks in other parts of the country, including the capital N'Djamena, led MSF to launch several vaccination campaigns as of April aimed at immunizing tens of thousands of children.
Staff in Chad (Sept. 2005): 56 international and 405 national.

Sudan (Darfur & South-Sudan) – Two years after the violence began driving people from their homes in the Darfur region of Sudan, little has improved for the two million displaced people and humanitarian assistance continues to be needed as the conflict goes on. Faced with high rates of diarrhoea, respiratory infections, and malaria; appalling water and sanitation conditions in many areas; and outbreaks of meningitis and hepatitis, MSF has worked to provide medical care, nutritional help and safe water in 32 locations across Darfur.
Despite a peace deal for southern Sudan, humanitarian assistance continues to be needed due to recurrent medical emergencies (caused by both disease and malnutrition), sporadic fighting and a massive return of refugees to areas with little or no access to care. MSF has been providing basic health care via hospitals, health centres and mobile clinics, has cared for malaria, sleeping sickness and kala azar (visceral leishmaniasis) patients, and provided nutritional support to malnourished children and their families in Upper Nile, Bahr el Ghazal, West Equatoria and Jonglei states.
Staff in Sudan (Sept. 2005): 348 international and 4,871 national.

DR Congo (response to conflict & emergencies, health care) – MSF has been using deristricted tsunami money to fund part of its 2005 operations in the eastern regions of the country where violence continues to flare, and to support its Congo Emergency Team. MSF carried out an emergency intervention to support tens of thousands of people who fled fighting in the Ituri District. The temporary abduction of two MSF staff members in June 2005 unfortunately forced MSF to suspend its mobile activities outside of the town of Bunia. In Katanga province where clashes between militias and the army continued to wreak havoc, MSF has provided a wide range of services including primary and secondary health care, treatment for malnutrition, emergency surgery, mobile health care, long-term tuberculosis treatment and care for victims of sexual violence. The Congo Emergency Team or "Pool d'Urgence Congo" (PUC) was created nine years ago by MSF to respond to sudden events such as disease outbreaks, displacement and natural disasters. In 2005 it responded to outbreaks of pulmonary plague, measles, bloody diarrhoea and cholera throughout the country and continued to assist 15,000 displaced people in Katanga province. **Staff Ituri, Katanga, and PUC (Sept. 2005): 71 international and 1,150 national (Total staff in DRC: 233 international and 2,133 national).**

Angola (Marburg & sleeping sickness) – When an epidemic of Marburg hemorrhagic fever was confirmed in March 2005 in Angola's northern province of Uige, MSF teams arrived a few days later to assist the local health authorities. The MSF intervention included setting up and managing the isolation unit where patients were cared for, maintaining hospital infection control and reinforcing universal precautions. MSF also assisted with case finding and contact tracing, ensuring safe burial practices, and maintaining water and sanitation systems. Teams conducted community education and epidemiological monitoring and analysis. While most cases were reported in Uige town, emergency units were also set up in the capital Luanda, in Songo and Negage (Uige province) and Camabatela (Cuanza Norte province).
Sleeping sickness or Trypanosomiasis is making a vengeful comeback in Angola where part of the Tsunami funds have helped to support the sleeping sickness programme in Caxito, capital of Bengo province, in 2005. In addition to treating patients, MSF conducted active screening campaigns to identify and treat new patients, mostly in remote areas. Since the beginning of 2005, MSF screened more than 11,000 people and treated a total of 215 patients.
Staff in Angola (Sept. 2005): 80 international and 1,099 national.